**A picture containing food, drawing

Description automatically generatedCYP Outreach Service Referral Form**

**Please read the following guidance.**

By completing this referral form, you’re helping us to make contact safely and quickly. Please ensure that you include as much information as possible - this saves the family being asked the same questions twice and helps us to understand more about their particular needs and circumstances.

**How to submit this referral:**

Please submit this referral by emailing it to [childsupport@swindonwomensaid.org](mailto:childsupport@swindonwomensaid.org).

We will acknowledge receipt of the referral within 24hrs. We will make initial contact with the family within 3 working days following receipt of the referral.

***Essential criteria when referring into this service:***

|  |  |
| --- | --- |
|  | **Please tick** |
| *CYP who have an awareness/understanding of, or who have experienced/witnessed domestic abuse within their home or the wider family.* |  |
| *CYP ages 7 – 17yrs, living in the Swindon area.* |  |
| *CYP not currently living with a perpetrator of domestic abuse**.* |  |
| *CYP who are willing to engage in 1 to 1 support sessions with a regular outreach support worker.* |  |
| *CYP displaying signs of emotional & behavioural issues as a direct result of exposure to domestic abuse.* |  |
| *Consent from the non-abusive parent/carer must be sought prior to referral.* |  |

***Please also consider the following:***

* *Are there any risks to working with this CYP? E.g., risk of escalation from the perpetrator of the domestic abuse.*
* *Is the CYP already engaged in other interventions of a similar nature?*

**How to get in touch:**

If you have any questions about our service, eligibility criteria, or how to make a referral, please contact:

Swindon Women’s Aid 24hr Helpline 01793 610610

SWA Children’s and Young People’s Outreach Support Worker – Katie Woolhouse

SWA Children & Young People’s Outreach Service Manager – Charlotte Gibbon

|  |  |  |
| --- | --- | --- |
| 1. **Information about the person making the referral** | | |
|  | | |
| Date of referral: | |  |
| **Please indicate which service you’d like to refer to:** | | |
| CYP Outreach Support | | |
| **Please enter your name and contact details:** | | |
| Referrer’s name |  | |
| Organisation name |  | |
| Role/ job title |  | |
| Contact number |  | |
| Contact email |  | |

1. **CYP contact info.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CYP Details** | | | | | |
| First name | |  | | | |
| Last name | |  | | | |
| Other names | |  | | | |
| What do they like to be called? | |  | | | |
| DOB | |  | | | |
| Current Age | |  | | | |
| **Parent/Guardian Details** | | | | | |
| Name of Parent/Guardian: | |  | | | |
| *Is it safe to directly contact this parent/carer? Yes No (please highlight)* | | | | | |
| Phone Number | |  | | | |
| Email Address | |  | | | |
| Current Home Address | |  | | | |
| Safe contact notes | |  | | | |
| **EMERGENCY CONTACT INFO**  **Next of kin if different to the parent/guardian** | | | | | |
| Name | |  | | Relationship |  |
| Contact information | |  | | | |
| Safe contact notes | |  | | | |
| **School/College info:** | | | | | |
| Which school/college does the CYP attend? | |  | | | |
| If there is a pastoral worker or someone who is working with the family that is already aware and supporting this CYP, please tell us their name AND contact details if possible | |  | | | |
| **Safeguarding** | | | | | |
| Are children’s services involved in this case? | | Yes  No Don’t Know | | | |
| Level/ nature of involvement – notes:  (If the CYP has a social worker, please give us their name) | |  | | | |
| **Accessibility requirements** | | | | | |
| Does this CYP have any accessibility requirements (for example, hearing loop, braille documents) | Yes  No  Don’t Know | | *If yes, please provide details:* | | |
| Do they have any allergies? | Yes  No  Don’t Know | | *If yes, please provide details:* | | |
| Does this CYP require an interpreter? | Yes  No  Don’t Know | | *If yes, please provide details:* | | |

1. **Client Equalities Monitoring**

|  |  |
| --- | --- |
| How would this client describe their gender? | Female  Male  Other *(please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  Don’t Know |
| Is their current gender **different** to the sex they were assigned at birth? | Yes  No  Don’t know |
| Do they consider themselves to have any kind of disability?  (please tick any that apply) | Physical  Learning  Mental Health  Deaf/ hearing impaired  Blind/ visually impaired  Other *(please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  Don’t Know |
| How would they describe their ethnicity? | |
| White British  White Irish  White Gypsy or Irish Traveller  Any other White background  Asian British  Asian Indian  Asian Pakistani  Asian Bangladeshi  Any other Asian background  Chinese  Arab | White and Black Caribbean  White and Black African  White and Asian  Any other mixed/ multiple background  Black British  Black African  Black Caribbean  Any other Black background  Other *(please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  Don’t Know |
| Do they have a faith/ religion? | |
| No religion  Bahai  Buddhist  Christian  Hindu  Jewish  Jain | Muslim  Shinto  Sikh  Zoroastrian  Other *(please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  Don’t Know |
| If appropriate, what is their sexual orientation? | Heterosexual  Gay woman  Gay man  Bisexual  Other *(please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  N/A |

1. **CYP Support Needs/ Vulnerabilities**

|  |  |
| --- | --- |
| **Please tell us more about any support needs the client may have:** | |
| Mental Health  Physical Health  Sexual Health  Substance misuse  Aggressive behaviour  Self-harming/ suicidal feelings | Educational attainment/ attendance  Social isolation  Bullying/ being bullied  Experiencing abuse  Other *(please specify below)* |
| **Additional details:** | |
|  | |

1. **Siblings**

|  |  |
| --- | --- |
| **Please provide names and DOBs for any siblings below:** | |
| Name | DOB |
|  |  |

1. **Reason for Referral**

|  |
| --- |
| **It is important that this section is completed in detail. Please consider these questions when completing this section:**  *What has been going on?*  *How long has this been going on for?*  *Can you tell me who is involved?*  *Is the CYP having contact with the perpetrator of the domestic abuse? If so, please tell us more about that.*  *Tell us more about the behaviours, fears, worries or anxieties of the CYP.*  *How do you think SWA could help?* |
|  |
| **Are there any known risks to working with this child?** |
|  |
| **Please tell us about any other support this CYP is receiving and when this due to end, e.g., STEP, Seeking Solutions, CAMHS/TAMHS, ELSA etc** |
|  |
| **Has the parent/guardian of the CYP consented to this referral** |
|  |

Thanks for taking the time to complete this referral.

To submit your fully completed document, please email [childsupport@swindonwomensaid.org](mailto:childsupport@swindonwomensaid.org)

**Before you send the referral, please ensure that your referral meets the criteria set out on the first page of this document.**

Please attach any other relevant documents that would support this referral.